DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
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FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

MCIM

03 JUN 2005

MEMORANDUM FOR Commanders, MEDCOM Major Subordinate Commands

SUBJECT: Electronic Medical Record (EMR) Summit

1. I would like to thank all of you for your participation in the recent EMR Summit at Fort Gordon. The importance of this event in facilitating the medical transformation of the AMEDD can not be overstated. The Summit brought together all Regional Medical Commanders and subject matter experts to galvanize a singular AMEDD strategy for the continued full deployment and future enhancements of CHCS II.

2. As I stated at the Summit, our focus on CHCS II is not meant to stifle "local entrepreneurial spirit." Our aim is to harness that spirit to develop enhancements that do not just address local issues in a stovepipe fashion, but rather benefit and improve care in every AMEDD facility. Our collective resources, energy, and expertise must be leveraged to serve the entire MEDCOM.

3. Enclosed you will find an Information Paper summarizing the points agreed upon and action items from the Summit. Please ensure these are shared with your staff along with the information papers and briefings presented at the Summit and archived online on the AKO CHCS II site at (logon to AKO first) https://www.us.army.mil/suite/page/406.

4. In summary, I wish to emphasize the following:

a. CHCS II is the AMEDD EMR and its use to document all clinical care into a single data repository is expected.

b. All interim EMR systems are to be retired at the earliest possible time so that limited resources can support enhancement of our medical care and CHCS II.

c. As CHCS II is implemented command-wide, all local record systems and documenting tools will be retired.

d. Local patient care databases will be discontinued and a plan will be developed to transition from present databases to CHCSII.

Encl

KEVIN C. KILEY
Lieutenant General, MC
Commanding

SUMMARY

MCIM 17 May 2005

SUBJECT: Decisions Reached at the Electronic Medical Record (EMR) Summit

1. Purpose: This document is to provide all AMEDD commands with information on the decisions reached during the recent AMEDD Electronic Medical Record (EMR) Summit held 29-30 March 2005 at Fort Gordon, GA.

2. Decisions:

a. CHCS II is the AMEDD and MHS electronic medical record. All other interim systems will be retired at the earliest possible opportunity. No further development or deployment of interim EMR systems is to occur with the single exception as noted under the Individual Medical Readiness module. CHCS II will be used as the data entry method for patient care.

(1) Goals:

(a) Single data-entry system at point of clinical care and a single repository of all patient medical information available to all CHCSII users.

(b) Effective utilization of AMEDD resources to fund further enhancement of CHCS II.

(2) Actions:

(a) CIO's Office to conduct data call of all MTFs to report on the following:

(1) Any electronic medical record system.

(2) Any medical database to include those used for research.

(3) Any medical note-writing or documentation equipment.

(4) Information on the purpose of the system, the scope of use, and the cost to include personnel to use and maintain.

(b) The CIO's Office and AMEDD CHCS II Program Office will develop a strategy to retire redundant systems and replace databases with access to the CHCS II database.

b. The Individual Medical Readiness (IMR) Module developed in MedBase and now integrated into CHCS II will be the standard AMEDD clinical application for documenting the healthcare provided as part of IMR screenings in clinics and Soldier Readiness

Processing (SRP) sites. It will be referred to as the Individual Medical Readiness Module of CHCS II.

(1) Goals: All clinician entered IMR data is part of the EMR and the data is used as appropriate for medical readiness tracking in MedPros and Soldier readiness tracking in DARTS.

(2) Actions:

(a) The AMEDD CHCS II PM will ensure that SRP sites are added to the CHCS II fielding schedule.

(b) SRP sites using MedBase or MedPros to document IMR will transition to the CHCS II IMR Module as CHCS II is fielded to those sites.

(c) MedPros PM will facilitate an interface for the CHCS II IMR Module which will also be used by MedBase until its retirement.

(d) MedPros PM will ensure real-time data acceptance from CHCS II and MedBase and real-time feed to the DARTS system.

(e) BAMC, as the AMEDD Center of Excellence, will lead development and enhancement of the IMR module to meet IMR requirements as approved by AMEDD governance. The MedBase IMR Module and the IMR Module in CHCS II will be kept in synchronized development until the retirement of MedBase. This is the only authorized development of MedBase.

c. The Outcomes Management efforts in HealtheForces at MAMC will be developed for CHCS II using the Clinical Data Mart (CDM) and transitioning to Clinical Data Warehouse (CDW) when it becomes available. The AMEDD will establish specific reports that can be defined for the end-user (PCM, OIC, command, etc) or condition.

(1) Goal: Leverage the data in the EMR to improve care through evidence-based medicine.

(2) Actions:

(a) RMCs will work together via AMEDD EMR CCB to establish the content of these reports.

(b) MAMC will be the AMEDD Center of Excellence for maintaining and updating this outcome reporting capability that is approved through AMEDD governance.

d. The Automated Clinical Practice Guidelines (aCPG) development effort at TAMC will be incorporated into CHCS II.

(1) Goals: Leverage the computing power of the EMR to provide point of care data retrieval, decision support, and reminders to improve consistency and quality. Permit use of enterprise and customized patient registries and outcome tracking.

(2) Actions:

(a) The AMEDD CHCS II PM will ensure the completion of the initial aCPG toolkit in CHCS II.

(b) The AMEDD CHCS II Program Office will work with TAMC and the MEDCOM Quality Management Office to post and develop CPG encounter documentation forms for use with CHCSII.

(c) TAMC will be the AMEDD Center of Excellence for aCPG development for use in CHCS II. It will work through AMEDD governance to define further CPG enhancements while maintaining aCPG functions.

e. AMEDD-Sponsored Development on CHCS II provides the opportunity to improve the MHS EMR and meet AMEDD requirements. All AMEDD-funded EMR development is to be done on CHCS II and with a defined plan to integrate the work into CHCS II for enterprise release. This will involve close work with CITPO who is the TMA program office for CHCSII.

(1) Goal: Leverage MTF expertise and proximity to the clinical environment to rapidly develop high-value enhancements to CHCS II.

(2) Actions:

(a) CIO Office to report on cost, schedule, and recommendations for the methods of developing a common development platform for desired program development into CHCS II. This will be briefed for TSG decision.

(b) CIO and CHCS II PM Offices will complete work with TMA to establish the methodology to ensure that AMEDD-development or AMEDD-funded development meets all requirements for efficient integration into the CHCS II baseline.

(c) CIO office will develop the process for review and approval of AMEDD-sponsored development through AMEDD governance based upon the CIO's brief of service-sponsored development at the Summit. The TASM and CIO office and USAMITC will develop a central process to support service-sponsored development.

f. We will adhere to the MHS schedule for CHCS II deployment to AMEDD MTFs. If use in a specific clinic/specialty represents a substantial step backwards in functionality compared to an existing interim application, Commander, MEDCOM, may decide to defer use in specific clinics until necessary enhancements are made to CHCS II.

Authority to exempt clinics from CHCS II use is retained by Commander, MEDCOM, and will not be delegated.

(1) Goal: Balance provider acceptance, acceptable functionality, and maximum CHCS II use to fully populate the EMR and derive clinical and management data to improve care and conserve resources.

(2) Actions:

(a) HeF CCB to complete prioritization of I-N list of HealtheForces functionality desired in CHCS II.

(b) AMEDD CHCS II PM & CIO office to prepare a review of I-N list and recommend clinics where CHCS II use should be deferred pending necessary enhancements.

(c) Analysis to be reviewed by CMWG and TIGOSC for approval to include timeline for retirement of interim systems by facilities.

(d) AMEDD CHCS II PM and CIO Office will work with CITPO to accelerate development and fielding of the Clinical Data Mart, the drawing tool, and the OB flowsheet.

(e) AMEDD CHCS II PM and CIO Office will assess the usability of CHCS II in Emergency Rooms and identify necessary enhancements.

3. Items requiring further discussion:

a. Availability of CHCS II at SRP sites on installations not currently on the deployment schedule, at CBHCOs, and prison health clinics.

(1) CIO office will develop and report on a plan to equip (computer and CDR connectivity) all such sites.

(2) AMEDD CHCS II PM will develop and report on a plan to train and sustain such sites.

(3) Progress on above will be updated quarterly and addressed at the next EMR Summit (November 2005).

b. Availability CHCS II or CHCS II-T at garrison BAS (fixed, not TDA locations).

(1) CIO office to develop action plan/recommendation to address this need.

(2) PM MC4 will field and maintain equipment to support CHCS II-T in garrison.

c. Availability of CHCS II from home.

(1) Providers often require the ability to review medical information from home. This capability exists in CHCS and is needed with CHCS II.

(2) AMEDD CHCS II PM office to work with CIO office to devise possible near-term solutions.

(3) AMEDD CHCS II PM office to track and report on progress of MHS efforts to provide access via TOL.

d. Reach-back access to patient information in the CDR from the deployed environment.

(1) The availability of patient information could enhance care in the deployed environment and reduce the need for evacuation from theater. Issues of connectivity, bandwidth, and security will influence the best solution.

(2) Further discussion needs to occur to decide on what echelon of care needs access to patient-specific data. This discussion will define the requirements for use of CHCS II and CHCS II-T.

(3) AMEDD CHCS II PM will develop a list of possible strategies in conjunction with MC4 PM to meet this need.

e. State of inpatient CIS/CHCS II interface.

(1) Pharmacy orders in CIS must flow automatically to the legacy CHCS pharmacy module and the CHCS II pharmacy module when fielded.

(2) Discharge summaries in CIS must flow to CHCS II.

3. The importance of this Summit cannot be overstated, nor can the importance of the healthcare transformation that the AMEDD is undergoing. Success will be achieved by the efforts and dedication of individuals at every level within the AMEDD. The progress of CHCS II deployment and development will be constantly monitored. In light of the importance of this endeavor, the AMEDD will conduct a second EMR Summit to evaluate progress of CHCS II and to focus more closely on the issues facing the tactical EMR. This Summit is tentatively scheduled for October or November of 2005.